FUNDING REGIONAL HEALTH SERVICES IN ALBERTA

A REPORT BY THE

HEALTH SERVICES FUNDING ADVISORY COMMITTEE

May 28, 1996

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EXECUTIVE SUMMARY

The Health Services Funding Advisory Committee (HSFAC) was appointed to recommend a regional funding framework to the Minister of Health. It provides the 17 Regional Health Authorities (RHAs) with the flexibility they need to develop innovative, consumer focused, effective and efficient health services which meet the health needs of their resident populations. It creates a new allocation of resources for regions according to the needs of their residents.

HSFAC's recommendations apply only to funding for services which are within the current RHA mandate; about 60% of the total health budget. Funding for air ambulance, fee-for-service payments to health practitioners, services provided by the Alberta Cancer Board and by the Provincial Mental Health Board are excluded.

The recommended funding framework has three major components:

1. Population needs-based funding is shared between regions according to the number of people resident in each region adjusted for:

   a) age and gender,
   b) socio-economic health risk

   Population needs-based funding will include 90 percent or more of total regional funding.

2. Funding for province-wide services. Province-wide services are distinguished by complexity, high service intensity, high cost and the need for highly specialized providers. They are expected to be available in only one or two sites in the province. This component is about 4 percent of total regional funding.

3. Other funding: Adjustments are made for:

   a) the increased cost of providing assured access to areas of the province with sparse populations, and
   b) increased costs of inputs - supplies and services in remote regions.

HSFAC is also recommending that:

- Regions providing services for residents of other regions be reimbursed from the population needs-based allocation to the home regions.

- A Population Health Needs Innovation Fund be established to support new approaches to understanding and meeting health needs. The Innovation Fund should be built up to about 1% of total regional funding over a three to five year period. It should be funded separately and not come from the regional pool.

- The new funding system be phased-in to buffer the impact of change. New funds provided should be allocated to regions funded below their population needs-based targets.

- A high priority be given to the development of an information system which will provide accurate and up-to-date Alberta case costs in all service areas (e.g., acute care, long term care, community services) along with descriptions of service activity by type, place of service and residence of person receiving the service. This work has begun as the Provincial Costing Project.

There are a number of areas beyond its mandate which HSFAC believes need to be addressed as part of a comprehensive approach to health services funding in Alberta. They are: funding for medical education and research, fee-for-service payments to practitioners, programs managed by provincial health boards, emergency services, capital, aboriginal health services and regional boundaries.

In making this report to the Minister of Health, HSFAC is suggesting a framework for funding. Design and implementation of the management and accountability infrastructure will be the responsibility of Alberta Health working with the RHAs.

1.0 INTRODUCTION

The Health Services Funding Advisory Committee (HSFAC) was appointed by the Minister of Health in January, 1995 to:

> *"recommend to the Minister a funding framework for future years which adequately addresses the long term objectives and guiding principles of Alberta's health restructuring, dealing first with the allocation to Regional Health Authorities."*

The current health funding methodology in Alberta was developed for institutions and agencies in a governance model that no longer exists. It focused on health care and placed emphasis on institutional care; rewarding utilization. These characteristics are not suited to the objectives of Alberta's Health Restructuring and Reform.

The first task of the Committee was to define the principles of reform and the organizational characteristics of our restructured health system, as they relate to funding. These principles and characteristics were validated through extensive consultation with all major stakeholders. They are the foundation for the proposed funding framework.

2.0 PRINCIPLES TO GUIDE THE DEVELOPMENT OF A NEW FUNDING METHODOLOGY IN ALBERTA

PREAMBLE

The province of Alberta has made sweeping changes in the governance and delivery of health services. Seventeen Regional Health Authorities (RHAs), the Provincial Mental Health Board and the Alberta Cancer Board have responsibility to provide an innovative, consumer focused, community responsive, efficient and effective system.

The Alberta Health 3-Year Business Plan (February 1995) describes the Principles, Goals and Strategies, and preferred Future Characteristics of the Alberta Health System. The core services as defined in the Health Plan Co-Ordination Project (HPCP) document, "*Core Health Services in Alberta*" fulfil the requirements of the Canada Health Act.

I Major Characteristics of the Organizational Framework of the Provincial Health System

- Governance of services is through the 17 RHAs and the two Provincial Health Boards.
- The emphasis and service delivery models are being changed:
  - There is greater emphasis on prevention of illness and promotion of wellness leading to greater community and personal responsibility for health.
  - Components of services and sectors are being integrated.
  - Resources are being redirected from an institutional and treatment focus to the community and preventative focus.
- Mobility and cooperation between regions is to be preserved for patient choice and comprehensiveness of services; funding must follow the workload.
- Certain tertiary and all provincial programs serve their own and potentially all regions.

II Principles for Management Information and Standards

- Information standards should be province-wide and transferable.

- Methods to determine costs for services to be developed on a province-wide basis and used as provincial standards for reallocating funds for:

  (a) services outside the region of residence.
  (b) certain province-wide services.

- An accountability framework, to be developed by each RHA and Provincial Board, should include:

  - Needs assessment in their areas of responsibility.

  - A business plan which identifies programs and costs to meet those needs.

  - An annual assessment of value for money based on:

    - outcome measures (including consumer satisfaction and community satisfaction).

    - performance measures.

    - regional fiscal accountability (i.e., services to be provided within the budget).

      Accountability would emphasize linkage to program needs and outcomes, not to specific services or funding.

- Other items needed by the Minister or the RHAs.

III Principles for Funding Methodology

- A basic block of funding (population needs-based) to all RHAs.

- Funding should flow between regions for services provided outside the region of residence on a fully costed out, provincially standardized basis.

- Province-wide Services to be funded separately based on established utilization criteria and provincially standardized costs. Research and Education are provincial services.

- Province-wide Services funding and policies should be regularly reviewed by a group with province-wide representation; not only the regions where the programs are located.

- The methodology should emphasize equity, simplicity, flexibility and transparency. Should there be a need to introduce compensating factors or adjustments to funding to a particular region, such factors or adjustments should be based on sound evidence, easily explained, and open to regular validation.

- The methodology should minimize administrative costs.

- Changes from the existing system would occur in a phased-in manner.

3.0 SYSTEM-WIDE ISSUES THAT REQUIRED CONSIDERATION

- Within the range of powers delegated to them, RHAs are authorized and responsible for spending the funds allocated to them in the way that makes maximum contribution to the health of their residents and ensures access to "core services". Accountability to provide value for these funds lies with the RHAs.

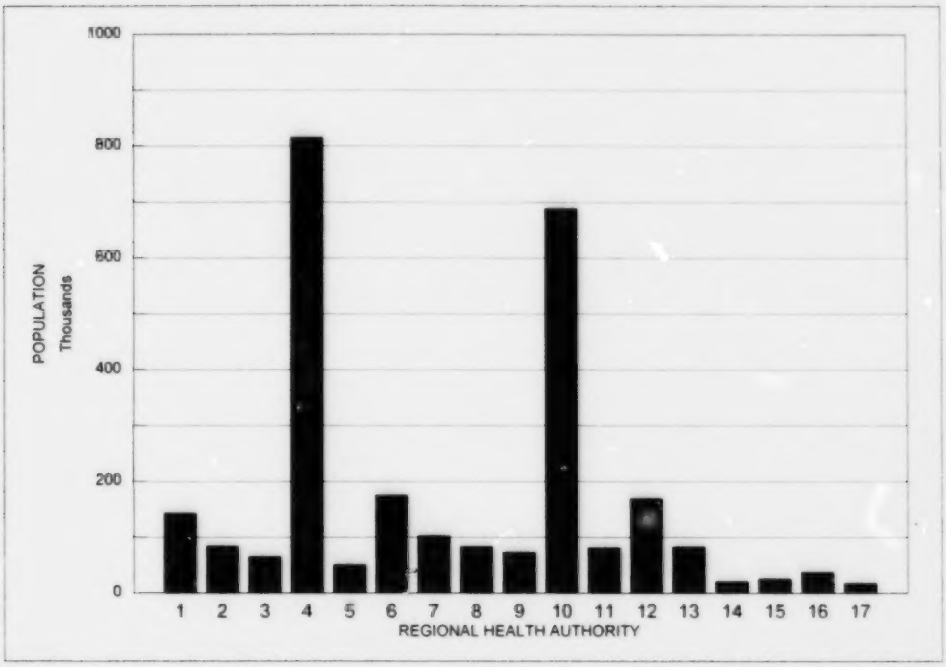
- All residents of the province can seek care in the location of their choice and health practitioners can make referrals to the specialist of their choice. Regional boundaries are not service barriers.

- Front line health services are provided in all regions; more complex services are available in larger regions which serve the smaller ones as well as their own populations; and all regions have access to high cost, high expertise, low volume services which are consolidated in a small number of urban centres to maintain quality and efficiency.

- There is considerable variation among the 17 health regions, as shown in Figure 1 on the following page:

» 55.7% of the province's population resides in the two largest regions, only 10.5% in the seven smallest.

Figure 1: 1994/95 Alberta Health Care Registration Population By Regional Health Authority



» There are large differences in the age groups residing in the regions, with a range from 1.9% to 14.5% of persons older than 64.

» While the most common causes of death are similar in most regions, one region, where "poisoning and injury" is the most common cause of death, stands out.

» The use of health services in the home region varies greatly. In the least self-sufficient region, 42% of residents seek hospital care in their region of residence; in the most self-sufficient, 98% of those who seek hospitalization get care in their own region.

4.0 SCOPE OF THE FUNDING BASE

The total funding for health services is determined by government through the political process.

A key aspect of the HSFAC mandate is to recommend an equitable way to share, between regions, the funding that is allocated to support the mandate of Regional Health Authorities (RHAs).

For this funding to regions, the HSFAC was asked by the Minister of Health to include the current regional funding pool comprised of acute care, long term residential care, community care, prevention, promotion and protection, community rehabilitation and laboratory services. The most important exclusions are the fee-for-service payments to practitioners, air ambulance services, AADL benefits, the two Provincial laboratories of public health, human tissue/blood services, capital construction and certain provincial programs, including payments to the Alberta Cancer Board and the Provincial Mental Health Board. The Provincial Mental Health Board activities are being integrated and reassigned to the RHAs.

5.0 REGIONAL FUNDING CONCEPTS

The Advisory Committee agreed at an early stage that funding should be provided to RHAs in a manner that is equitable based on populations served and regional characteristics that impact the cost of health services.

Furthermore, the funding should be as flexible as possible to allow development of innovation in community-based, person centred, integrated and cost effective health services.

The Committee studied relevant models of Regional Funding. "Regional Funding" is a term used to describe resource allocation in widely differing systems and regional structures. In Finland, it refers to more than 400 communes and a total population of 5 million; in Saskatchewan, it refers to 30 districts with 0.9 million people; in Britain, it refers to 14 regions with more than 50 million people. Regional funding in Alberta involves 17 regions and 2.7 million people. We learned that criteria for inter-regional fairness and equity cannot be simply transferred from one system to another because of differences in size of regions, their populations, scope of services available and methods of physician reimbursement. However, all these health systems have a major emphasis on population based funding.

6.0 PROPOSED FUNDING APPROACH FOR ALBERTA

The funding model was developed after a series of workshops, conferences, newsletters, visits to RHAs; reports by academics, providers, stakeholders and citizens and through analysis by technical committees and clinical panels. The current models in other jurisdictions were reviewed in detail.

The HSFAC proposes that the comprehensive funding allocated to regions be divided into two broad pools: Population Needs-Based Funding allocated to each RHA, and Province-Wide Services.

A. Population Needs-Based Funding

This component consists of population needs-based funding allocated to every region with maximum flexibility to deliver services in the manner most appropriate to the region.

For the system to be fair, population-based funding must consider more than numbers of people. Certain characteristics of populations have been identified which determine health needs and the cost of providing health services. Many population-based funding systems use the term "needs-based" to describe adjustments to simple per capita funding.

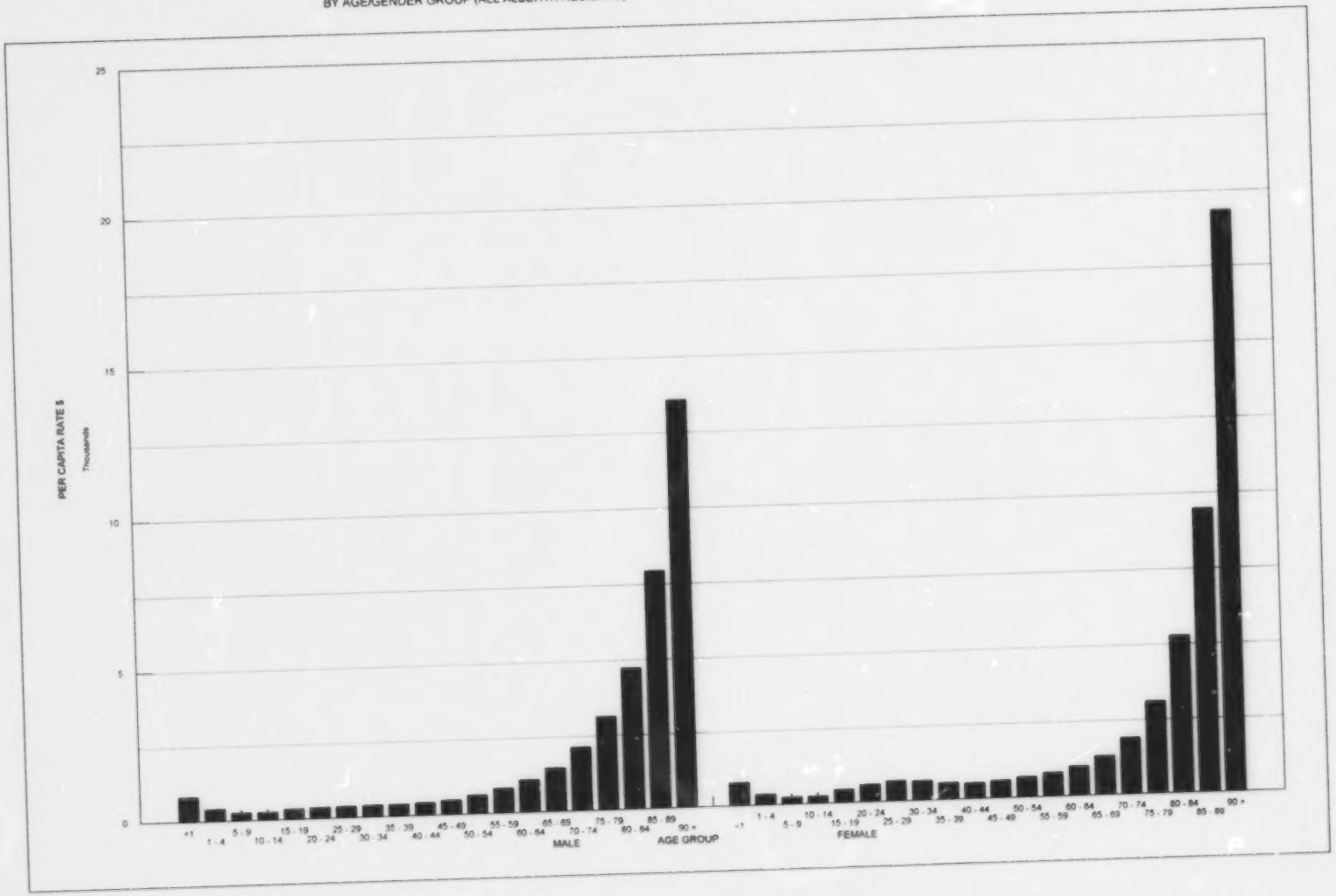
Age and Gender

Data from all industrialized countries indicate that increased health services are used (and presumably needed) in the first years of life, during reproductive years for women, and again with advancing age. As a result, all population-based funding systems make a major adjustment to per capita funding based on age, and most also adjust for gender. This is the most widely accepted and the largest adjustment to per capita allocations in population needs-based funding.

To make an age/gender adjustment, each resident in each region is assigned a weight based on the average resource utilization of persons in their age/gender group (taken from provincial utilization rates). The adjustment to per capita funding for each person is then used to determine total adjusted funding for all persons in each region. To illustrate the effects of this adjustment, Figure 2 shows 1994/95 age/gender weights for Alberta. Each region will get funding for all its population with an appropriate adjustment for the children, women in reproductive years and elderly in their region.

FIGURE 2 ESTIMATED 1994/95 PER CAPITA EXPENDITURE RATES

BY AGE/GENDER GROUP (ALL ALBERTA RESIDNTS)



NOTE - BASED ON 1994/95 REGISTRATION POPULATION (RHA EXPENDITURE EXCLUDING NON POPULATION BASED FUNDING)

Socio-Economic Health Risk

Studies in several countries have emphasized for many years that health is correlated with wealth and other measures of improved socio-economic status. The best health status is experienced by the highest socio-economic groups; the lowest health status is experienced by the lowest socio-economic groups. Alberta data, and data from other provinces in Canada confirms the relationship and documents that utilization of health services is higher in the lowest socio-economic groups.

The Committee views this issue as one where further understanding and new data will refine the funding implications in future years. However, to acknowledge the increased costs of providing services to this vulnerable group, we are recommending that regions be provided additional funds for all persons under age 65, who are in the lowest socio-economic portion of the provincial population.

This adjustment, for aboriginal people and non-aboriginal low income persons, adjusted for age and sex, is provided to each region based on the number of persons in each socio-economic groups. See Figures 3, 4, and 5.

The low income groups are identified by their eligibility for Alberta Health Premium subsidy/waiver. Low income non-aboriginal population who constitute 19% of Albertans and aboriginals (treaty status), who account for about 4% of Albertans are included in this under age 65 group. The non-aboriginal premium support group includes the poor unemployed, the low education working poor, persons on social assistance, non-treaty Indians with low income and single parents who are poor.

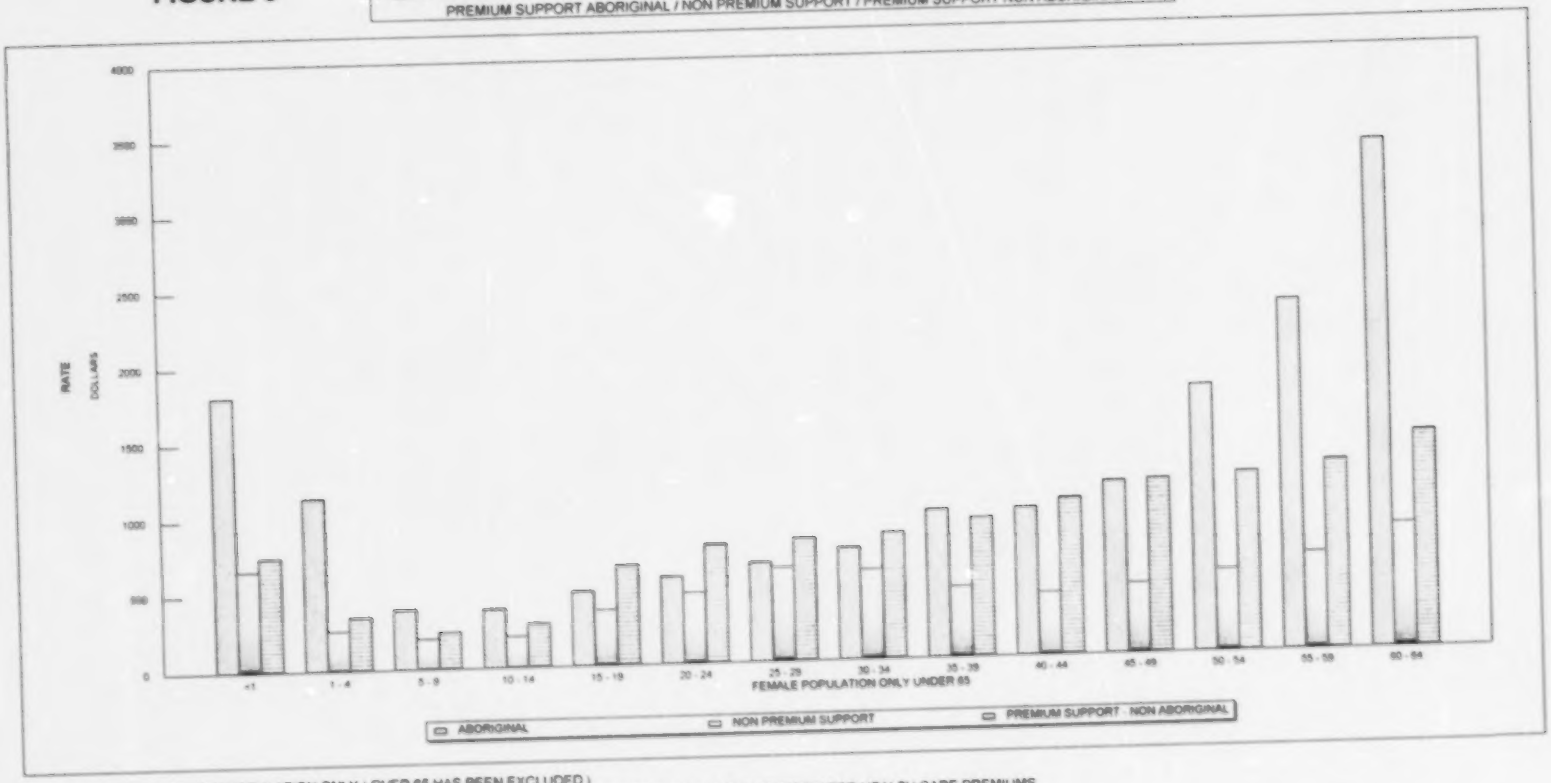
Since there is insufficient evidence that increased health care services alone improve the health of these people, RHAs are encouraged to creatively explore opportunities to address root problems such as early childhood and family development, employability and education for these groups in addition to serving their immediate health needs.

This socio-economic health risk adjustment represents the second largest adjustment to per capita funding. The total expenditure impact for the age/gender, and socio-economic health risk adjustments is illustrated in Figure 6.

FIGURE 3

PER CAPITA EXPENDITURE RATE - FEMALE POPULATION

PREMIUM SUPPORT ABORIGINAL / NON PREMIUM SUPPORT / PREMIUM SUPPORT NON ABORIGINAL



NOTE 1 FEMALE POPULATION ONLY (OVER 65 HAS BEEN EXCLUDED)
2 PREMIUM SUPPORT MEANS THOSE ALBERTANS WHO QUALIFIED FOR PARTIAL/FULL SUBSIDY FOR HEALTH CARE PREMIUMS
TREATY STATUS ABORIGINALS HAVE THEIR HEALTH CARE PREMIUMS PAID BY THE FEDERAL GOVERNMENT

SOURCE HEALTH CARE UTILIZATION AND HEALTH CARE REGISTRATION FILE

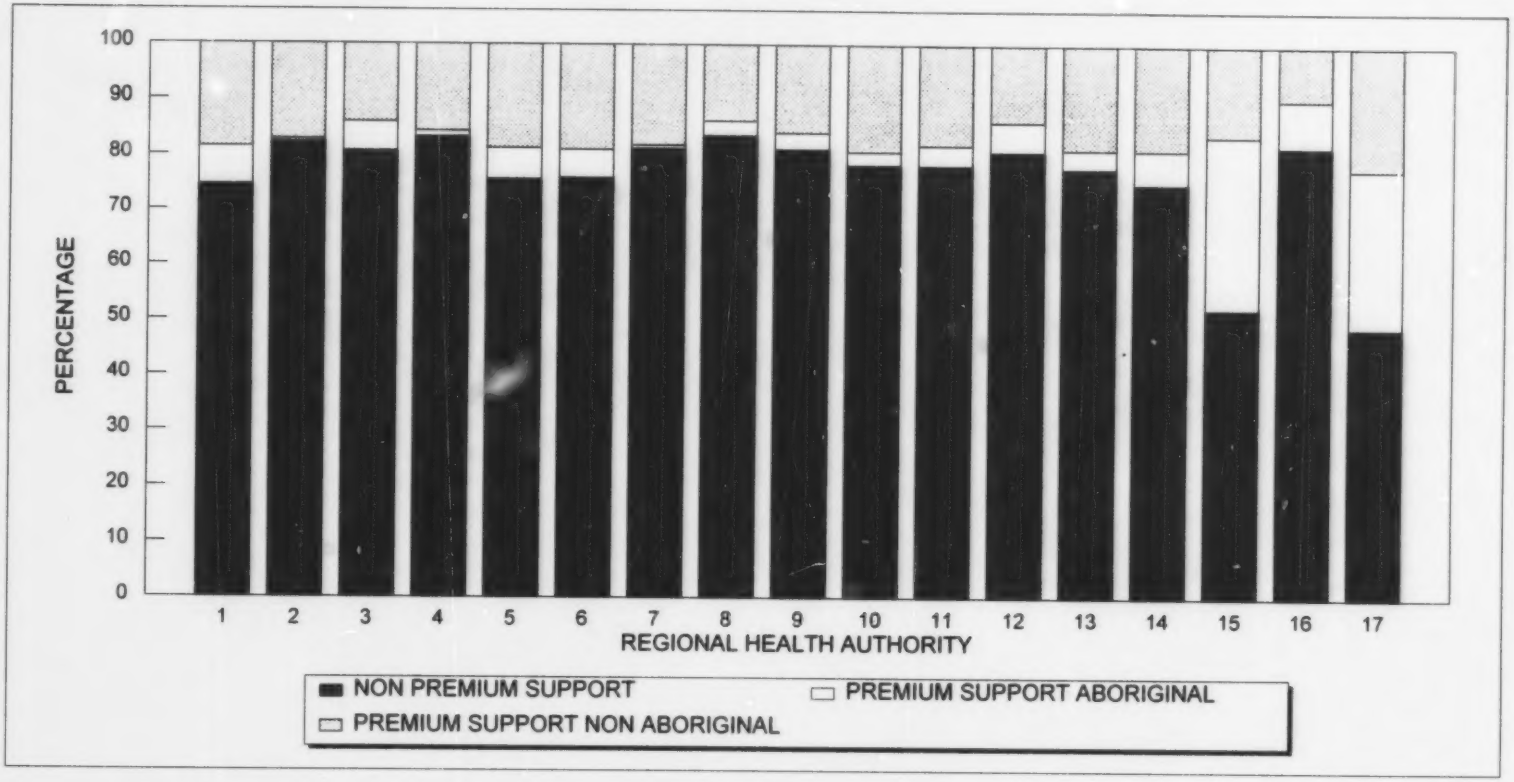
FIGURE 4

NOTE 1 MALE POPULATION ONLY (OVER 65 HAS BEEN EXCLUDED)
2 PREMIUM SUPPORT MEANS THOSE ALBERTANS WHO QUALIFIED FOR PARTIAL/FULL SUBSIDY FOR HEALTH CARE PREMIUMS
TREATY STATUS ABORIGINALS HAVE THEIR HEALTH CARE PREMIUMS PAID BY THE FEDERAL GOVERNMENT

SOURCE HEALTH CARE UTILIZATION AND HEALTH CARE REGISTRATION FILE

FIGURE 5 PERCENTAGE OF POPULATION BY SOCIO-ECONOMIC GROUP

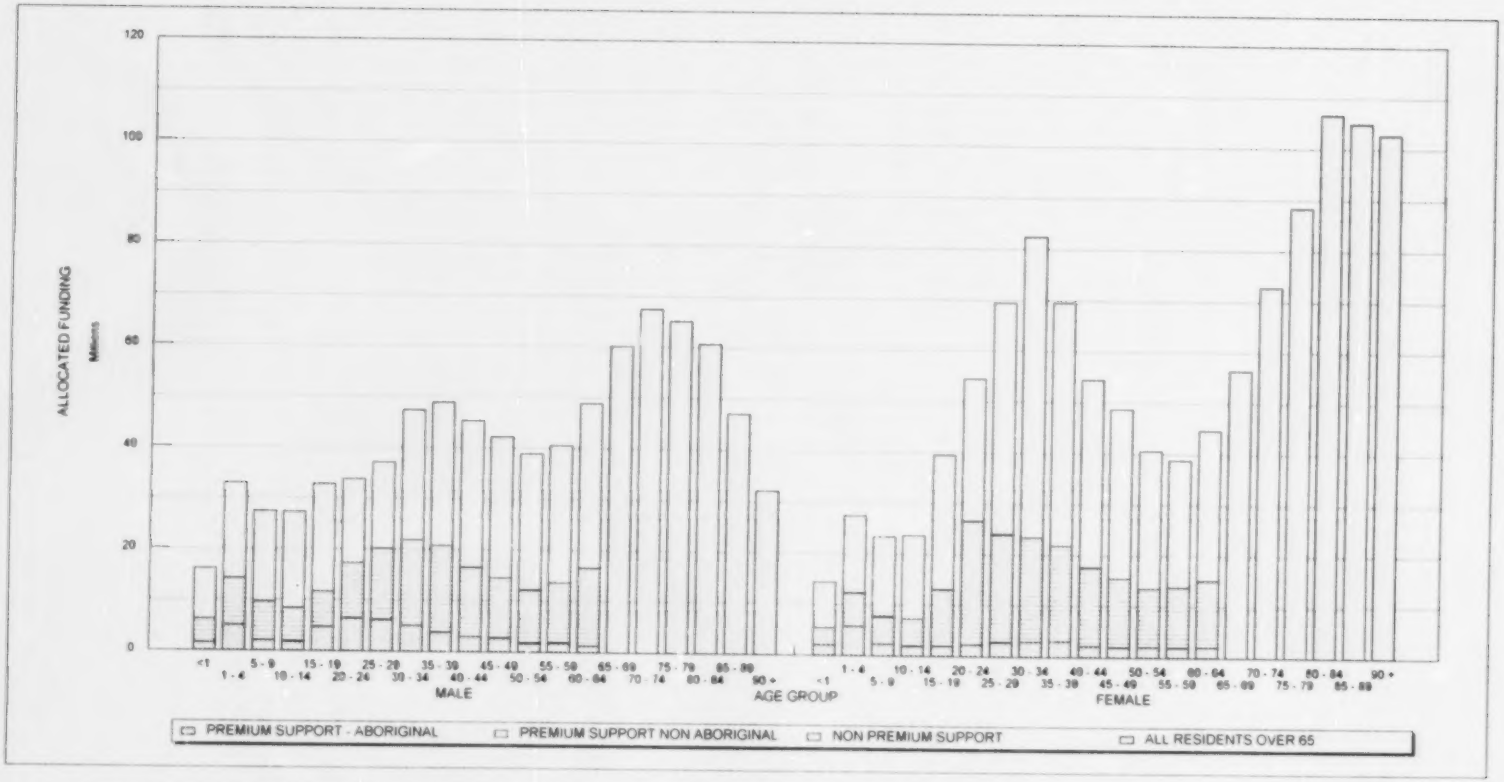
ALBERTA HEALTH REGISTRATION AS AT MARCH 31 1995



PREMIUM SUPPORT MEANS THOSE ALBERTANS WHO QUALIFIED FOR PARTIAL/FULL SUBSIDY FOR HEALTH CARE PREMIUMS.
TREATY STATUS ABORIGINALS HEALTH CARE PREMIUMS ARE PAID FOR BY THE FEDERAL GOVERNMENT

FIGURE 6

POPULATION BASED FUNDING ALLOCATIONS BY AGE/GENDER AND BY SOCIO-ECONOMIC GROUPS



NOTE PREMIUM SUPPORT MEANS THOSE ALBERTANS WHO QUALIFIED FOR PARTIAL/FULL SUBSIDY FOR HEALTH CARE PREMIUMS
TREATY STATUS ABORIGINALS HAVE THEIR HEALTH CARE PREMIUMS PAID FOR BY THE FEDERAL GOVERNMENT
PRELIMINARY- BASED ON 1994/95 ACTIVITY AND 1996/97 AVAILABLE DOLLARS

SOURCE HEALTH CARE UTILIZATION AND HEALTH CARE REGISTRATION FILE

Factors Considered But Not Recommended:

The Advisory Committee, the Methodology Working Group and the Needs Correlates Working Group deliberated on the appropriateness of many other factors. Other factors included unemployment, low cost housing and single parent families. After extensive studies, we found most indicators were either difficult to measure or not verifiable. Particular attention was given to "Standardized Mortality Ratio (SMR)" because it had been used in other jurisdictions. Also, this is a measure that is readily available. However, the committee believed SMR not to be a suitable factor for funding in Alberta because:

a) Each jurisdiction that has chosen to use SMR for funding has made different mathematical manipulations regarding how it will be applied in their setting with no scientific validation. The manipulations have also been adjusted over time.

b) The utilization data in Alberta does not correlate well with SMR according to studies provided to the group by Dr. Kyung Bay of the Department of Public Health Sciences, University of Alberta.

c) Year to year stability in SMR values is a problem in regions with small populations. High SMR values for a number of Alberta regions are not significantly different from the provincial average. Therefore, the indicator is not sufficiently sensitive and was found to be very volatile year over year.

d) The new funding formula is intended to promote health and the SMR is based on increased funding for premature death.

B. Province-Wide Services

The second broad pool of funds will consist of funding for high cost, high expertise province-wide services which should be provided in only 1 or 2 regions in the province. If each region had to pay for those services out of its budget, a couple of complex services could severely affect the budget of a region with a small population. These services will be funded based on identified need for services, and be available to all residents of every region. To ensure that the responsibility and resources are provincially focused, we recommend that a provincial body be established to review and advise on the allocation of province-wide services.

C. Other Funding

Many regional funding systems identify that providing core services to small and sparse populations has an increased cost over regions with larger populations living in higher density areas. The Correlates Group has evaluated the available data on this issue.

Sparsity of Population/Assured Access to Core Services/Added Cost of Providing Health Services to Low Population, Remote Areas

In the review of literature and discussions with other jurisdictions and several RHAs in Alberta, we were persuaded that a minimum allocation of funds is required to provide frontline services. Based on several preliminary models, and proposals from the RHAs, the working group developed criteria for consideration.

A service centre (hospital, community health centre or clinic) would be financially possible if there are 5,000 or more people living within a reasonable travelling distance of 30 minutes or 50 km of the centre. Population needs-based funding would provide more than 3 million dollars to that population.

We have mapped the entire province, and drawn lines around the towns which have populations near 5,000 or more, or where together with the surrounding communities within a 50 km drive, the population is equal to or greater than 5,000. All persons living outside of these circles are then identified as living in remote areas. See Figure 7.

We are proposing that these more remote populations be granted a supplementary allocation to meet the added costs of assuring a reasonable and essential front line level of service.

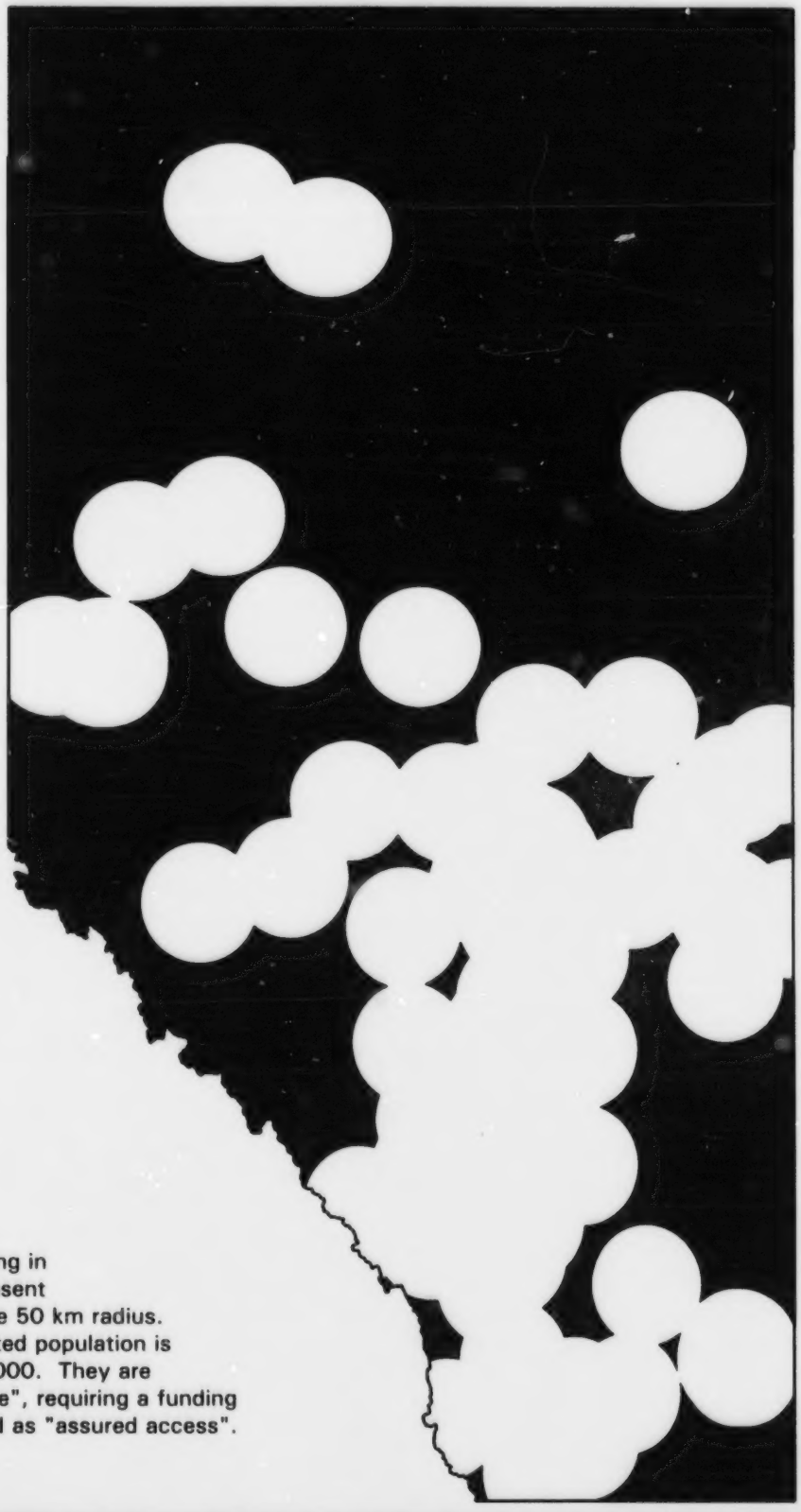
Using this criterion, regions with residents in the remote areas, 95,000 in total, will receive additional per capita funding. The supplement is 25% of the average provincial per capita rate.

Cost of Doing Business

In reviewing the 5 northern regions, there is a cost due to the long distance from a major supply centre, and due to the relatively low volume of supplies required. In addition, utility costs are higher and travel costs are substantially greater for health personnel.

FIGURE 7

Population Centres with 5,000 or more Persons with a 50 km Radius



The population living in shaded areas represent locations out of the 50 km radius. The total enumerated population is approximately 95,000. They are counted as "remote", requiring a funding adjustment labelled as "assured access".

Based on these considerations, those Regions whose major service centre is more than 300 km from a major supply centre (Edmonton or Calgary), would receive a supplementary allocation. This would be applied only to the supply and services component of Region expenditures. The proposed supplementary allocation is 25% of the supply component which in turn is 20% of total regional allocation. Only the 5 northern regions (Regions 13-17) qualify for this supplement.

Precise data to establish the level of adjustment is not available. These recommendations are based on best estimates from formulas under study in British Columbia, Quebec and other jurisdictions. These components of funding for assured access and the increased cost of providing services in remote areas represented approximately 1% of total regional funding.

D. Inter-Regional Services

All population-based funding will initially be assigned to the region of residence. However, in recognition of the services which residents from one region actually obtain from other regions, the corresponding funding will be transferred to the provider regions. The transfer to provider regions should be based on documented inter-regional activity and then reconciled quarterly.

Should residents of a region change their utilization of services from other regions, the funding would always be reallocated to the region where service is actually provided.

The reconciliation between regions involves standardized rates based on the best available cost estimates, or as established by the Provincial Costing Project. This mechanism should be reviewed on an on-going basis.

E. The Proposed Health Innovation Fund

A Health Innovation Fund is proposed as a major tool to refocus the system on population health.

Funding would be applied for by RHAs and administered through RHAs based on a process and criteria established by the Minister to include the following:

- Evidence that the problem is of major importance as a population health issue in that region or several regions, and that a truly innovative approach is being proposed.

- Cooperative plans by several regions if the problem is common to them.

- Strong participation of community members in the study/project.

- That the study takes a multi-disciplinary team approach to the assessment of need, evaluation of cases or implementation of an innovative intervention.

- That pilot projects be focused on community-based preventative strategies to reduce use of health services and support healthy living.

- Use of experience and best outcome benchmarks from other RHAs or other population experience.

- A strong study plan, or well documented pilot project including a method to evaluate the impact of the study or pilot project, and a realistic budget.

- The study/project would be funded through the Innovation Fund for a maximum of 3 to 5 years. Highly successful and cost effective innovations will then be adopted by the sponsoring RHAs and supported out of their population needs-based (i.e., regular) funding.

- The focus of the Innovation Fund will be to create more effective and efficient health services.

F. Summary

This funding approach supports the Regional Health Authorities' responsiveness to needs in three ways:

- Well documented needs are recognized in the funding for each region. These include age, gender, socio-economic health risk, and the effects of sparsity of populations and remoteness on the costs of providing core health services. Interregional patient flow is an additional factor.

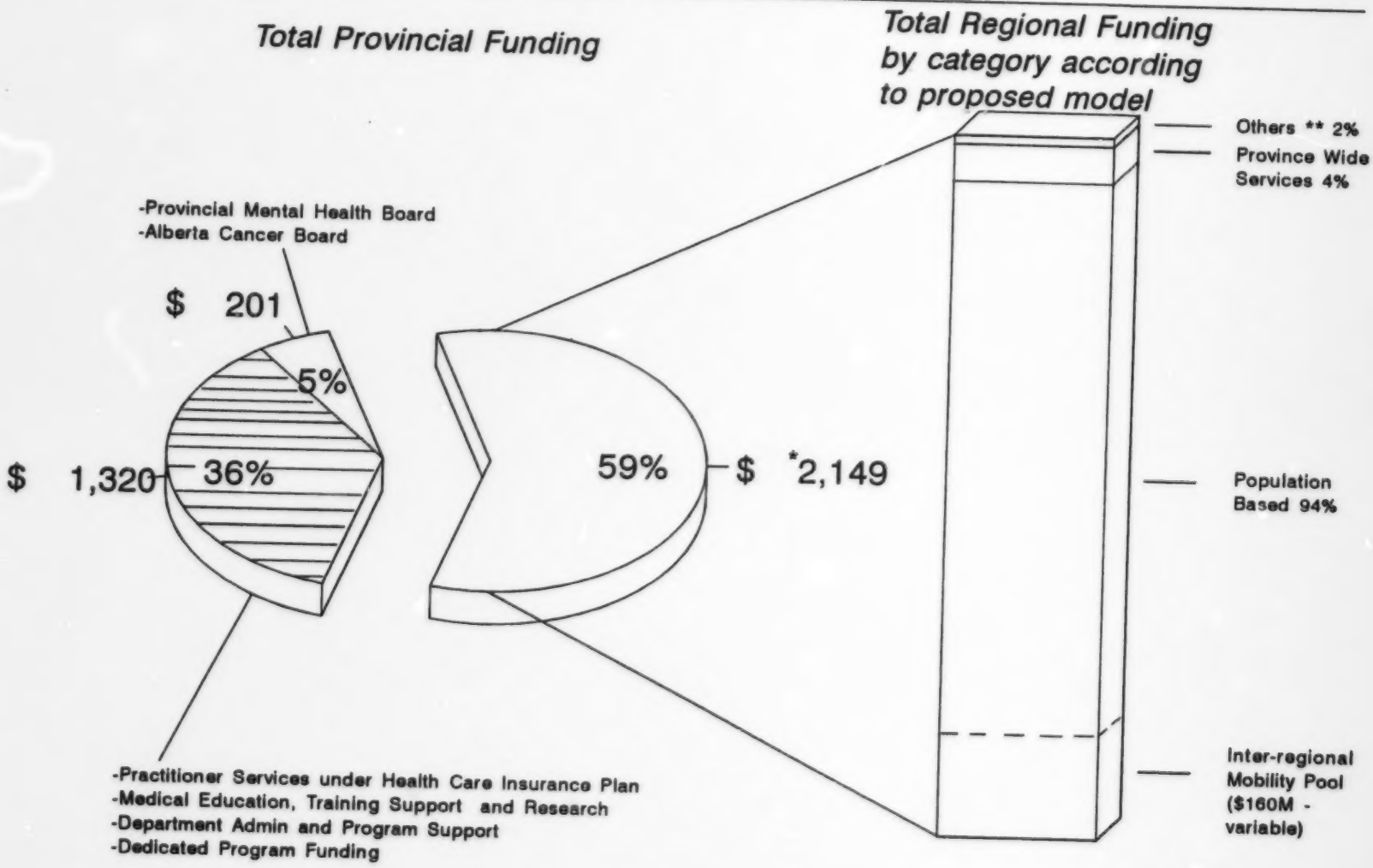
- Province-wide services are "needs responsive" in that patients generally seek these services on referral, and these services support all regions. They will be reviewed regularly to ensure that the needs of the regions are being served.

- In addition, we are recommending that a Health Innovation Fund be established, to support studies and pilot projects which would lead to innovative preventive health or health services solutions for important problems in any or all regions.

A summary of the components of funding is provided in Figure 8. A comparative analysis of total expenditures by population and age group is shown in Figures 9 and 9A for males and females, respectively.

Figure 8: Components of Health Funding in Alberta

1996/97 Estimates - ($ Millions)



* Excludes one time funding to Calgary, Capital and Westview RHAs ($25M)

** Others include valuation for Indirect Teaching, Cost of Doing Business, Assured Access and some Health Innovation Funding

FIGURE 9 TOTAL MALE POPULATION AND EXPENDITURE BY AGE GROUP

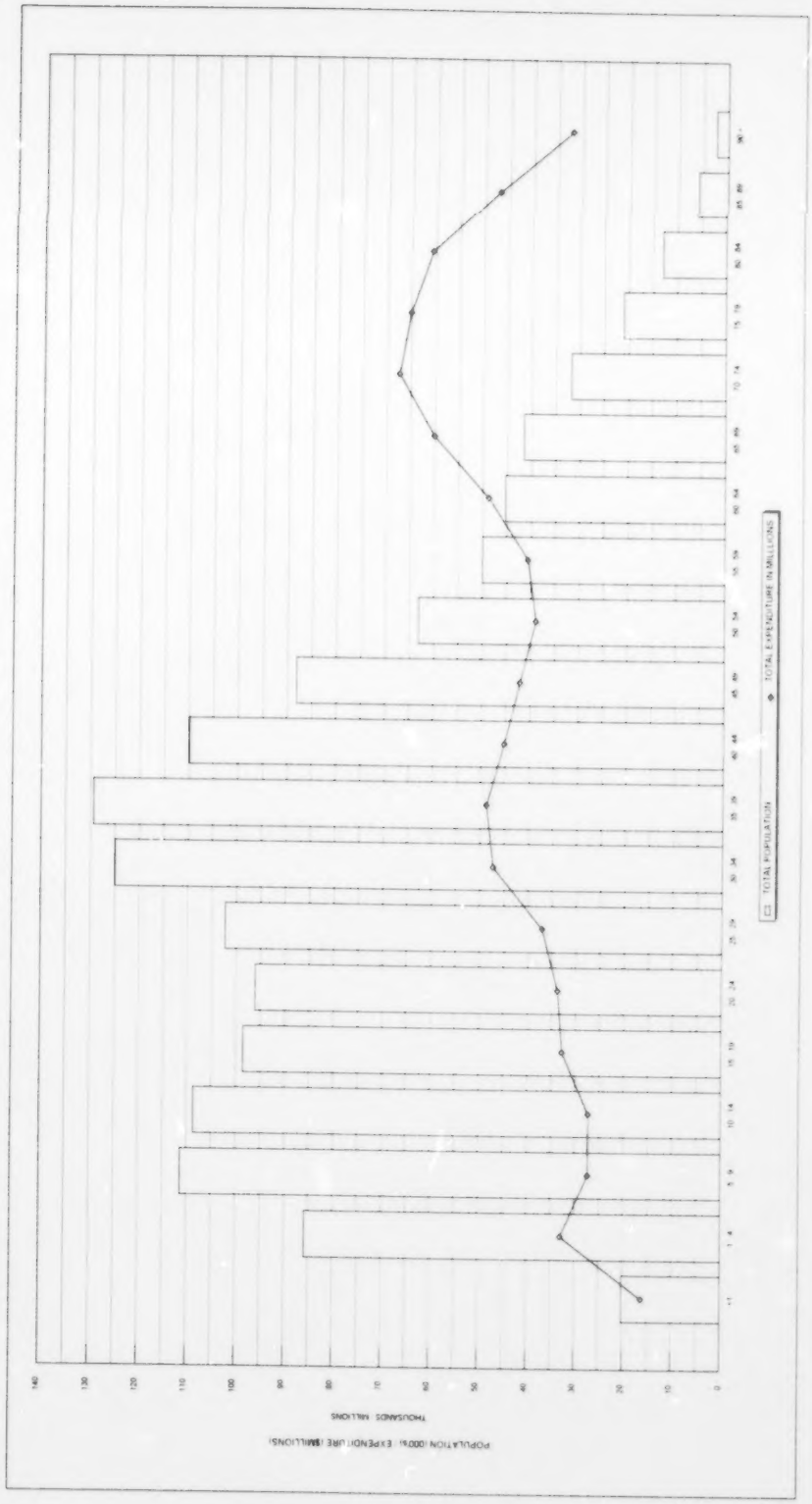
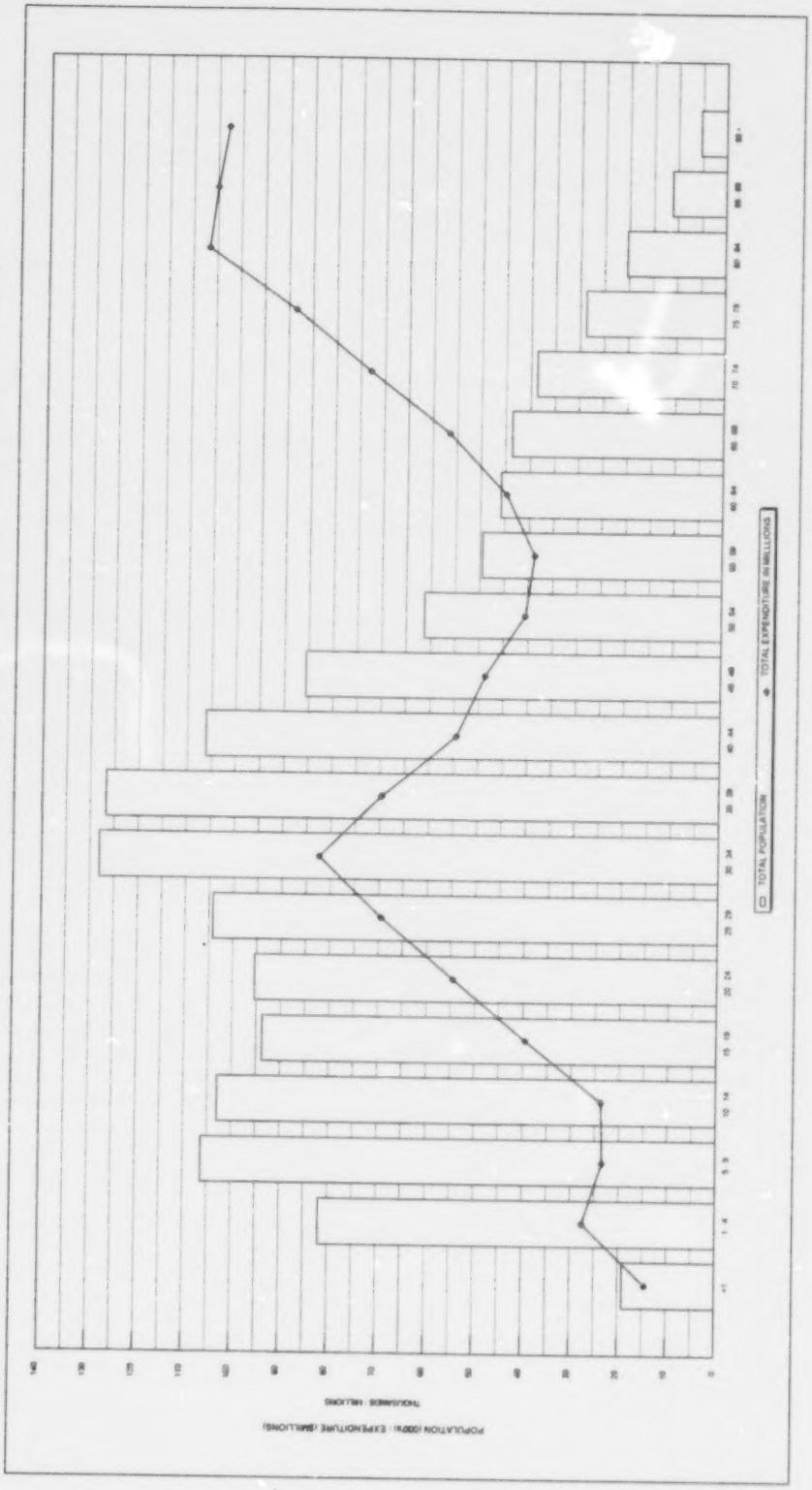


FIGURE 9A TOTAL FEMALE POPULATION AND EXPENDITURE BY AGE GROUP



7.0 RECOMMENDATIONS

RECOMMENDATION 1:

Principles

- That the Minister of Health accept the funding principles proposed by HSFAC as the basis on which all regional funding decisions will be made.

RECOMMENDATION 2:

Funding Pools

- That regional funding be provided in separate portions for:

  - **Population Needs-Based Services** - Services available in most or all regions.

  - **Province-Wide Services:** - Complex, low frequency, high-cost services which, for reasons of quality and efficiency, should be available in one or two sites.

    - Medical education and research in the two academic health centres.

  - **Other Funding For:** - The increased cost of providing assured access to areas of the province with sparse population.

    - Increased costs of inputs - supplies and services in remote regions.

RECOMMENDATION 3:

Population Needs-Based Funding

- That the pool of funds designated for population-based services be distributed among regions in the following way:

- The population of each region and demographic information be established and annually updated using the Alberta Health Insurance Registration File, which includes all eligible residents.

  The Registration File should be maintained by Alberta Health in a way which accurately reflects the number of eligible residents within health regions.

- Funds be allocated to each region based on the resident population of the region (as established annually from the Registration File) with adjustment for age and gender, socio-economic health risk, and added cost of providing services or access in sparsely populated areas.

- A commitment be made to buffer changes in funding during transition from the old to the new funding framework.

RECOMMENDATION 4:

Allowances for Mobility; Population-Based Services

- That the costs of population needs-based services provided by one region for residents of another be reimbursed to the providing region from the home region.

  In order to give provider regions stable and predictable funding and, at the same time, give referring regions the flexibility to break old service patterns, the mobility payments should be reviewed on at least a quarterly basis using data from the most recent quarter available (3 month delay).

  HSFAC expects that changes in referral patterns would be based on sound program planning and consultation between referring and provider regions. Quality of service and expertise, accessibility and efficiency need to be assured.

  It is expected that regions will develop joint arrangements for some population-based services where residents of one region might receive services in another. Compensation for services provided to out-of-region residents could be by arrangement between regions or through the mobility reconciliation.

  HSFAC recognizes that mobility allowances for long term care raise special issues. When a person enters a long term care facility, it is usually permanent. The long term care facility becomes home. If the long term care placement involves crossing a regional boundary, the new region will benefit when the annual population adjustment is made and the individual will be counted in the new region. But it immediately incurs the costs of long term care.

A standard procedure for transferring funding between regions when a resident of one region is placed in a long term care facility in another region should be established.

RECOMMENDATION 5:

Province-Wide Services

- That the definition of province-wide services developed by the Committee be adopted and reviewed from time to time as technology and practice guidelines change. This will require that a provincial body be established to carry out an annual review and recommend revisions to the list of province wide services.

  For funding purposes, province-wide services are defined by their complexity, their high service intensity, their cost and their need for specialized providers. They would be available in only one or two sites in the province. Medical education and research have been defined as province-wide services.

- That province-wide services be funded on the basis of projected volumes of service and relative value case costs (established by the Provincial Costing Project).

RECOMMENDATION 6:

Information Support

- Accurate and timely information is required to support these funding arrangements. The Committee recommends that a well coordinated province-wide information system be developed to provide activity and cost data in all service areas. With appropriate provisions for protection of individual privacy and data security, the data should be available to RHAs, Provincial Boards and Alberta Health.

  The Provincial Costing Project should be continued until its activities can be incorporated into the work of Alberta Health.

RECOMMENDATION 7:

Related Issues

During the course of its deliberations, HSFAC identified a number of issues that were outside, but ancillary to, its terms of reference. These have been repeatedly emphasized by stakeholders during our consultations. Resolution of a number of these issues is important to the equity of funding of health services in Alberta.

- ***Funding for medical education and research, and the broad issues affecting funding for Academic Health Sciences Centres.***

  HSFAC recommends that a mechanism be set up to evaluate the needs and provide a proposal for long term funding of Academic Health Sciences Centres (AHSCs). As a prerequisite to this process, the AHSCs should be requested in discussion with RHAs, Alberta and other important stakeholders, to define their roles and responsibilities in the new health system.

  The issues to be addressed in teaching and research need redefinition. The approach to service activities could take the direction of defining principles that are important in reimbursement of academic staff to ensure that they are able to perform the core components.

- ***Reimbursement for fee-for-service physicians.***

  Although this area is outside the scope of the terms of reference of HSFAC, the Committee felt compelled to provide some general comments. On one hand, the 17 RHAs have the responsibility to set priorities for health services in their regions based largely on the Health Needs of those regions as they are able to define them.

  On the other hand, it is recognized that currently, physicians as "gatekeepers", have great influence as to the spectrum and volume of services provided.

  For RHAs to be successful in their mandate, it would appear necessary to review incentives or disincentives that may exist in the reimbursement mechanisms to ensure that they allow for alignment of physician reimbursement and practice with the Health Needs.

- ***Different funding sources.***

  In some regions, a portion of services such as ambulatory services are funded from the Alberta Health Care Insurance Plan rather than the RHA budgets. The funding of these services should be reviewed and made consistent with the approach taken within this report.

- ***Programs Managed by Provincial Boards.***

  Both the Alberta Cancer Board (ACB) and the Provincial Mental Health Board (PMHB) operate programs and provide services which are essential components of the health system in Alberta. Plans are currently in place for restructuring mental health services.

HSFAC recommends that the funding for Mental Health and Cancer Services be reviewed and made consistent with the approach taken to funding other services offered by the regions.

- ***Emergency services.***

Successful restructuring of acute care hospital services within a region is dependent on coordination of the RHAs "emergency health services network." This includes 24-hour acute care hospital resources, dispatch and telecommunications, inter-facility transfer protocols, ambulance services, medical direction and deployment of ambulance attendants.

HSFAC recommends that funding for ambulance services be reviewed, and that any barriers to service integration and coordination created by the way services are funded be removed.

- ***Capital.***

HSFAC recognizes that different approaches to capital funding, involving the transfer of capital funds to RHAs and provincial boards, may be appropriate. However, a proper balance must be established between the RHA role in making decisions affecting health delivery and government's responsibility for determining the availability of provincial resources and the fairest allocation of those resources.

Some types of capital work may be better suited to formula funding than others. Also, there may need to be some correlation between the magnitude of the capital investment and involvement of government. When RHAs are allocating funds to providers in their regions, consideration should be given to the way capital is dealt with, particularly where both public and private operators provide comparable services.

- ***Aboriginal health services.***

HSFAC sees the need for closer collaboration among governments, native leaders and communities regarding the provision of Aboriginal Health Services. According to the data available to the Committee, Aboriginal people have higher than average illness burdens, use more health services and are funded from several sources. The Committee recognizes the special relationship between the Federal Government and First Nations. It encourages the Minister of Health to:

- improve innovation,
- avoid duplication between federal and provincial services and funding, and
- ensure that all available funding is used as effectively as possible.

- ***Regional boundaries.***

  HSFAC recommends that the regional boundaries be reviewed so that health services can be delivered more efficiently and the regional planning process made simpler.

  HSFAC recognizes that any regional structure requires collaboration between regions and some interdependency will, and should, always exist.

  However, experts who have provided advice have identified the number of regions and the configuration of regional boundaries as an issue. There is a high level of interdependence between regions.

  In one region, only 40% of the residents, who are hospitalized, are admitted to a hospital in their own region. Another region spends more than 20% of its total budget on residents from other regions.

  HSFAC is suggesting that consideration be given to revision of some regional boundaries, reduction in the number of regions and/or combining regions into planning zones. Regions in a planning zone could develop their plans in a coordinated way and submit them to the Minister as a "package".

- ***Regional toolbox.***

  Once they receive population needs-based funding, RHAs will have to decide how to share the funding between programs, providers and service areas within their region. The RHA decisions will address most needy populations within their regions, as well as effective and efficient use of resources. Data about utilization patterns, socio-economic health risks and service costs used by HSFAC will be useful to RHAs.

  HSFAC recommends that data tools be developed as a provincial resource and made available to all RHAs.

  Joint arrangements between Alberta Health and RHAs need to be put in place to manage:

  - Province-wide funding; keep the definitions current, maintain accurate up-to-date cost data, allocate funds between the referral centres.

  - The Innovation Fund; application procedures need to be designed, proposals received, assessed and funded (or not).

- ***Ongoing Management.***

  The proposed funding system will present new opportunities and challenges. Alberta Health needs to provide leadership in the administration and management of the new system.

8.0 IMPLICATIONS OF THE PROPOSAL

The proposed funding approach is very different from the one currently used. It eliminates the incentive structures and constraints that are now in place and gives RHAs freedom to make disincentive decisions in the best health interests of their residents. With the exception of the funding provided for province-wide services, which are estimated to be about 4% of the regional total, funding is no longer determined by the amounts required to run a hospital or a long term care facility or a home care program. Relative health needs determine regional funding shares.

In the HSFAC's view, the strengths of the proposal are:

- Funding is aligned with health goals and RHA mandates, and should encourage interest in improving "population health."

  Health goals and RHA mandates are directed at improving population health; funding levels are determined by the number of people in a region and their needs. RHAs are accountable for the health of their resident population.

- There is freedom to move funding to services which have the greatest payoff; funding barriers between programs are broken down; there is maximum flexibility.

- It encourages negotiation between adjacent regions on import and export of services. This can mitigate "losses" for referring regions and improve service delivery.

- Activities (more hospital visits, more residents in long term care, more home visits) are no longer rewarded for their own sake; RHAs are not penalized if they stop doing things that are not important for their region.

- The funding approach is easy to understand. It is not gameable. The Committee has avoided many potential but poorly understood and complex adjusters to maintain simplicity and fairness. A practical approach that works well has been preferred to a theoretical formula that tries to accommodate all alleged variations between regions.

- The approach protects small regions against the catastrophic costs of unpredictable high-cost cases; province-wide services are funded separately.

- Innovation is encouraged; funds are specifically allocated to new ways of meeting population health needs.

- There is freedom of choice for people seeking service and referring practitioners. Except for province-wide service, out-of-region service is paid for by the home region.

Like any change in strategic direction, there are some uncertainties and some problems which will have to be worked out. The following issues are ones that need to be kept in mind and dealt with during implementation.

- The fairness of the funding approach depends on accurate population counts and case costs.

  The Alberta Health Insurance Registration File provides the best available estimates of population. The Registry needs ongoing validation with respect to region of resident, age and gender. However, there is a natural incentive for each RHA to get all residents registered, which will improve accuracy.

  Reliable costing data is critical if province-wide and out-of-region services are to be funded appropriately.

  In the past, Alberta has used New York case weights as proxies for acute inpatient care and there are major gaps in costs for ambulatory and community services. While estimates may serve for a short introductory period, the gaps need to be filled quickly with Alberta data.

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- Health Needs Correlates Working Group